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STATUE IN MEMORY OF LUIS MORQUIO
Founder of the American International Institute for the Protection of Childhood
Montevideo, Uruguay

UNITED STATES
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CHILDREN'S BUREAU

THE CHILD

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CONTENTS

	Page
SAFEGUARDING THE HEALTH OF MOTHERS AND CHILDREN:	
Care for Every Mother at Childbirth—	
The Job Ahead, *by J. W. Mountin, M. D.*	35
A Basic Plan, *by Martha M. Eliot, M. D.*	35
New Evidence on the Effect on the Infant of the Mother's Diet During Pregnancy	38
INTER-AMERICAN COOPERATION:	
Inter-American and National Services for the Children of the Americas, *by Katharine F. Lenroot*	42
First National Child-Welfare Congress in Peru	46
EVENTS OF CURRENT INTEREST:	
Death of Dr. A. T. McCormack	47
Resolutions of National Education Association	47
Conference Calendar	47
"Back to School" Campaign	48
New and Revised Children's Bureau Publications	48

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UNITED STATES
DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF

WE ARE fighting again for human freedom and especially for the future of our children in a free world. Children must be safeguarded—and they can be safeguarded—in the midst of this total war so that they can live and share in that future.—*A Children's Charter in Wartime.*

• SAFEGUARDING THE HEALTH OF MOTHERS AND CHILDREN •

Care for Every Mother at Childbirth

[Both these articles are based on remarks made at the twenty-fifth anniversary meeting of the Maternity Center Association, New York City, April 30, 1943.]

The Job Ahead

By Joseph W. Mountin, M. D.
Assistant Surgeon General, U. S. Public Health Service

Giving birth to a child is a painful, hazardous, and expensive procedure. Contrary to widespread belief, childbearing has many of the characteristics of an illness. Years ago Dr. De Lee pointed out that pregnancy brings organic and psychic symptoms identical with those of illness. It also brings disability in various degrees. Like sickness, it often results in permanent bodily damage or impairment of function, and sometimes in death. To these three points of similarity I would add another—that of the cost in dollars and cents.

If we regard pregnancy and childbirth as a form of sickness, I can think of no sickness that responds so well to even the simplest forms of medical attention. For example, a century ago in Vienna, Semmelweis reduced the maternal death rate in his clinic from 16 to 3 percent in a single year, merely by insisting that the attending physicians wash their hands in an antiseptic solution.

Besides preventing deaths the objectives of maternity care are to insure that the woman will carry her child to term and give birth to a live baby, to reduce to a minimum the discomforts and disabilities of pregnancy, to ease the pain and diminish the risks of labor, and to insure that no lasting disablement befalls either the mother or the child.

How many women in this country receive medical and hospital care at childbirth?

During 1941 in the United States there were two and a half million live births. Of these,

(*Continued on page 39*)

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A Basic Plan

By Martha M. Eliot, M. D.
Associate Chief, U. S. Children's Bureau

Today the American people see that we can no longer be prodigal of the lives of women in the child-bearing and child-rearing period of their lives. Nor can we be prodigal of the lives of their newborn babies, or of their older children. War has made us see how greatly the virility and tone of our democracy depend on the skill with which we rear children to be strong of body, sturdy of spirit, and understanding of heart.

Surely the first step toward this broad goal is the provision of universally good maternity care. European nations have long since taken steps to protect maternity. Countries like Sweden and Scotland have made efforts to provide for every mother and are constantly working to improve the quality of care. No comparable plan for care exists in any one of our States, but Congress in March 1943 made a significant move toward greater national recognition of public responsibility for the health of expectant mothers and their babies when it made special provision for the care of the wives and infants of men in certain grades of military service.

Congress has appropriated funds for medical, nursing, and hospital care for the wife and baby of any service man in the four lowest pay grades, without regard to income, residence, race, color, or creed. For April, May, and June of this year $1,200,000 was made available for allotment to the States cooperating in the program.[1]

[1] Congress later appropriated $4,400,000 for this program for the fiscal year ending June 30, 1944, and extended the coverage of the program to families of men in the first, second, and third pay grades.

The Children's Bureau has the responsibility for approving the plans made by the States for the use of the money. This is a function that the Bureau has in respect to all maternal and child-health plans under the Social Security Act, and it has been extended to include this supplementary program. Physicians will be paid for obstetric and pediatric care; hospitals will be paid on the basis of ward rates; nurses to help doctors in home deliveries will be paid; the visiting-nurse associations may be reimbursed for bedside care; trained nurse-midwives, under supervision of physicians, can be utilized if they are available; and social service will be made available through existing agencies.

Starting this program marks a red-letter day for the United States, for it is truly a program of public maternity care. It is small, to be sure, but its significance is great.

What would we have to do to assure good maternity care to every mother?

First of all, we have to make up our collective minds as to the basic philosophy on which we will proceed. Do we, as a Nation, intend to provide good care for every mother regardless of her place of residence, her race, and her financial status? Or are we going to be content with the makeshift plan we have today under which some mothers get the best care that is known anywhere in the world while others get along with no skilled assistance of any sort? When the people understand thoroughly what can and should be done, I do not doubt that they will insist on the first course. Given the will to provide good maternity care to every mother, the ways and means will be found.

What we want for every mother is easily stated: Medical care by a well-trained physician, starting, if possible, before conception or at least not later than the second month of pregnancy and given continuously throughout pregnancy, labor, and the puerperium; medical care for the newborn infant by a physician trained in the care of children; specialized consultant service readily available as needed by mother or child; nursing care by competent public-health and hospital nurses for the mother throughout the period of maternity and for the infant; hospital-clinic or health-center service for the prenatal and postpartum periods for all maternity patients who seek this type of care; delivery care and at least 10 days' postpartum care in a hospital with all possible safeguards for the health of the mother and newborn infant; facilities for boarding or convalescent care before or after delivery for those mothers whose physical condition or home situation requires it; the direct service of trained nurse-midwives working under the direction of a physician to assist with normal cases where there is an inadequate number of physicians to give necessary care; counseling service by a medical social worker in hospital and clinic to assure the provision of adequate food, shelter, clothing, and personal and family adjustment to the conditions of maternity.

This is the kind of care we want to provide. How soon can it be done? Can we not set ourselves a goal, a deadline? Is it out of the question to think that it can be developed year by year until within a decade the goal is attained?

Clearly, to make this type of care universally available within the next decade it is essential that a carefully worked out plan should be agreed upon at once and made ready for immediate use as soon as personnel and materials for construction are freed for civilian purposes after the war. This plan must take into consideration (1) the fixing of public administrative responsibility and methods of financing, (2) the preparation of alternative patterns of organization, (3) the establishment of standards of care, (4) the construction and equipping of new facilities needed to supplement those that exist now, and (5) the training of professional and technical personnel.

There would seem to be little reason why decisions should not be reached now as to the general framework and many of the details of a plan for public maternity care and medical care of children to be put into effect after the war. At best it will take 10 years to develop the program in all its parts; it may take longer. But today there is enough experience in this country and abroad to warrant laying down basic principles and a pattern of general procedure.

A review of this experience leads me to believe that the basic principles upon which we should build would be in general as follows:

1. Any public program of maternity care and medical care of infants and children should be the joint responsibility of local, State, and Federal Governments, financed under the grants-in-aid plan from general tax funds.

2. Administrative responsibility should rest with the State departments of health, with expenditure of Federal funds under plans approved by the Federal agency given responsibility for the grants.

3. The program should be State-wide in effect and be so organized as to include a network of maternity and pediatric services that will reach out from a few highly organized maternity and pediatric units in hospital and teaching centers to a chain of smaller hospitals and clinics located strategically in medium-sized cities and thence to the many small local maternity and child-

health units in towns and counties and rural areas.

4. Maternity care of good quality should be available under this program to any woman who seeks it, regardless of residence, economic status, race, color, or creed; eligibility should be on the basis of medical need alone.

5. Standards of care should be established by the responsible administrative agencies with the advice of experts in the various professional and technical fields.

6. Employment practices in the case of professional personnel should be determined, first, by the required standards of care and, second, by economy in the expenditure of public funds.

7. Hospital and clinic facilities meeting established standards of maternity and infant care and care of sick children should be available or easily accessible to every community, rural as well as urban; public institutions should be open to everyone in the community whether the community or the individual pays; existing voluntary, nonprofit institutions, if used, should meet established standards of financial accounting as well as professional service.

8. The plan for training professional and technical personnel should be part of the plan for service and should reach down from the most highly organized teaching unit to the smallest rural unit.

Obviously it is not a cheap line of goods that we as a Nation must buy. The total bill will be large because the goods must be "all wool and a yard wide." But we are already paying for a considerable proportion of it out of our individual pockets. If, instead, we should divide the total cost up and spread it out over the whole people in the form of general taxes collected by State and Federal Governments, annually it would probably not amount on the average to more than $2 to $2.50 per taxpayer.

With the termination of the war and the return of thousands of physicians to civilian life, a plan for intensive postgraduate training in obstetrics and pediatrics should be ready for those who wish to enter these fields of service. Opportunities for full-time or part-time employment in the public medical service (public-health or clinical) should be arranged in advance. Training must be supported by an equally well-devised plan for placement. The same provision must be made for nurses who on their return from military service may wish special advanced training in obstetric, pediatric, or public-health-nursing techniques.

With the cessation of war, raw materials for construction and for the manufacture of equipment will be available. Hospitals of all sizes and kinds will be built. A well-worked-out plan for maternity and pediatric units must be available in each State that will assure construction on the basis of need.

Obviously it is in rural areas that construction of maternity-hospital units must begin. We may need to revise our ideas as to what should constitute the smallest practical unit if we are to provide for these small towns and villages and farming areas. Perhaps in these rural areas, this smallest unit will have to be attached to a health center; perhaps it will be part of a small community hospital.

The best interests of the Nation would demand that only good care be tolerated and that standards of service be set and lived up to. General practitioners not already adequately trained could be expected to take postgraduate training. In a period of 10 to 15 years under a Nation-wide program combining service and training facilities, it is believed that a sufficient number of physicians could be given postgraduate training in obstetrics and pediatrics so that the services of physicians with such training could be made available to all parts of the country.

Conditions in the various States and in urban and rural areas would determine to a considerable extent the methods of payment for medical service. Having full-time salaried physicians in each hospital would certainly be the method of choice. In some areas payment on a part-time or case basis would be necessary. Supervision of service and administrative control would usually require full-time employment. In some of the rural areas experience may show that the full-time employment of well-trained nurse-midwives working under the supervision of physicians is the most effective and economical way of providing good obstetric care.

Each level of Government must play its particular part. Under our system the States stand in a position of great responsibility; but if, as is the case with such a vital program as maternity care, it is desirable and indeed necessary that all citizens concerned share equally in a service, then a pooling of resources and interests of all the States must take place through the Federal Government.

But actually the job must be done in each locality and the standards of care will in the last analysis depend on what the people demand. Throughout the process of planning and organizing any program of medical care, the planners and organizers cannot hope to go far ahead of what the people know they need and want. It is, therefore, the work done in the local community that counts in the end. Good care will not become universally available until the people themselves are keenly aware of the kind of care that should be provided.

Throughout the years great responsibility has been taken by private and voluntary groups of professional and nonprofessional workers for setting standards of maternity care, for training professional personnel, for developing techniques of care, for research, for advising government at all levels, and for informing the public of the kind of maternity care that should be expected. All this experience and the many facilities that exist today must be utilized in any expanding program of maternity care and medical care of children.

The question before all of us now is to decide how much we want a program like this.

We can achieve a safe and sound maternity-care program for every one of our mothers within the next decade, but only if we want it greatly. All we need to carry us through to the goal I have been picturing is the will to carry through.

New Evidence on the Effect on the Infant of the Mother's Diet During Pregnancy

Contrary to usual obstetric teaching, the adequacy of the mother's diet during pregnancy has a direct effect upon the physical condition of her infant, according to evidence presented by Bertha S. Burke and others, in a report entitled "Nutrition Studies During Pregnancy." This paper is one of a series reporting on a 12-year research program on the growth and development of the well child, undertaken by the Department of Child Hygiene, School of Public Health, Harvard University.[1]

As a step toward solving the problem of the extent of the dependence of the fetus upon the maternal diet, the authors studied the diets of 216 women in relation to (1) physical condition of the infant; (2) course of pregnancy—especially with regard to preeclampsia; (3) duration and character of labor and type of delivery; and (4) complications of the postpartum period.

The relationship between the adequacy of the mother's diet and the condition of the infant was found to be more marked than that between the diet and the course of pregnancy. "This indicates," according to the report, "that with an inadequate prenatal diet the fetus suffers to a greater degree than the mother. In other words, the fetus is parasitic upon the mother only to a certain extent, and that extent is limited apparently by the mother's nutritional state at the time she enters pregnancy and by the quality and quantity of her diet during pregnancy. It is of the utmost importance to realize this fact," say the authors, "because in the usual clinical examination during pregnancy it is not possible to evaluate adequately the condition of the fetus, and it is entirely possible that a woman may have an apparently satisfactory clinical course, but if she is consuming an inadequate diet the fetus will suffer."

The conclusions of the study are as follows:

1. This study has shown a statistically significant relationship between the diet of the mother during pregnancy and the condition of her infant at birth.

2. If the diet of the mother during pregnancy is poor to very poor, she will in all probability have a poor infant from the standpoint of physical condition. In the 216 cases studied, every stillborn infant, every infant who died within a few days of birth (with the exception of one), the majority of infants with marked congenital defects, all premature, and all "functionally immature" infants were born to mothers whose diets during pregnancy were very inadequate.

3. If the mother's diet during pregnancy is excellent or good, her infant will probably be in good or excellent physical condition. However, it may happen occasionally (1 out of 216 cases in this series) that a mother whose diet during pregnancy was "excellent" or "good" will give birth to an infant in poor physical condition.

4. A statistically significant relationship was found to exist between prenatal diet and the course of pregnancy. This relationship, however, is not as marked as that existing between the prenatal dietary rating and the condition of the infant. This indicates that when the nutrition during pregnancy is inadequate, the fetus suffers to a greater degree than the mother.

5. In this study, no mother whose diet during pregnancy was considered "good" or "excellent" had preeclampsia, while with a "poor to very poor" diet during pregnancy almost 50 percent had preeclampsia.

6. No statistically significant associations were found to exist between prenatal nutrition and the duration and character of labor and delivery. There was a tendency for the mothers whose diets during pregnancy were "poor to very poor" to have more difficult types of delivery and have more major complications at delivery, despite the fact that these women had, on the average, smaller infants than were born to the women whose diets were "good" or "excellent."

7. No relationships of statistical significance were found to exist between prenatal nutrition and the postpartum course. There seemed to be a tendency toward relationship between prenatal nutrition and the occurrence of major complications in the puerperium.

[1] Burke, Bertha S., M. A., Virginia A. Beal, B. S., Samuel B. Kirkwood, M. D., and Harold C. Stuart, M. D.: Nutrition Studies During Pregnancy. American Journal of Obstetrics and Gynecology, vol. 46, pp. 38–52 (July 1943). Single copies of a reprint of this paper may be obtained by writing to the Children's Bureau, Washington, or the Department of Child Hygiene, Harvard School of Public Health, 55 Shattuck Street, Boston.

Care for Every Mother at Childbirth; The Job Ahead—J. W. Mountin, M. D.

(Continued from page 35)

91 percent were attended by physicians. The remaining 9 percent were cared for by midwives or other nonmedical attendants.

This might seem to be a fair performance, but like most gross statistical expressions this one fails to indicate wide variations of great significance.

For example, the proportion of cases reported as not having a physician's care ranged from practically none in several States to approximately half in Mississippi. Medical attendance was more common in urban than in rural communities. In cities with a population of 100,000 or more only 1 percent of the cases were not attended by a physician; in cities from 10,000 to 100,000, 3 percent; and in small towns and rural areas, 17 percent.

There was also considerable variation among racial groups. Whereas only 3 percent of the live births among white people were not attended by a physician, the ratio among Negroes was approximately 50 percent.

Finally, the National Health Survey conducted by the United States Public Health Service in 1935–36 showed that there was a striking difference in the kind of treatment received by persons of different groups. Among the urban white population only 1 percent of the women in families with incomes of $2,000 or more lacked medical care at delivery, but 5 percent of those in families with incomes below $1,000 lacked such care.

Care Depends on Residence, Race, Income

The advantage of receiving hospital care during delivery is subject to the same determining factors—place of residence, race, and income—and here the deficiencies are even more pronounced. Thirty-nine percent of all the maternity cases in this country in 1941 did not receive hospital service. Nonhospitalized cases ranged from 6 percent in Connecticut to approximately 83 percent in Mississippi. Among white women only 34 percent lacked hospital care at delivery, but among Negroes, 73 percent. In cities of 100,000 or more, 10 percent of the deliveries took place elsewhere than in a hospital; in cities from 10,000 to 100,000, 17 percent; and in small towns and rural areas, 70 percent. Among the cases reported in the National Health Survey, only 12 percent of those in families above the $2,000 income level were not hospitalized, but among those below the $1,000 level, 45 percent.

Thus, broadly speaking, the type of care an expectant mother is likely to receive is determined by her place of residence, the color of her skin, and the amount of money she has. To be effective, future efforts to reduce maternal and infant casualties must be directed primarily towards correction of these basic inequities.

Unequal Distribution of Physicians and Hospitals

One of these inequities, namely, that related to place of residence, cannot be remedied until a more satisfactory distribution of physicians and hospital facilities is achieved.

Under our present systems of medical practice and hospital administration, physicians and hospitals tend to become ever more concentrated in centers of population and wealth. Even in 1939, before any doctors were requisitioned for military service, New York State had a ratio of 1 physician to 500 population, whereas Mississippi had only 1 to 1,400, a difference of nearly 3 to 1. In metropolitan counties of the Nation the physician-population ratio was nearly twice as high as in nonmetropolitan counties. In counties with per capita income of $600 or more the ratio was about 3 times as high as in counties with per capita income of less than $300.

Studies made by the United States Public Health Service show that this lack of balance has been growing steadily worse over a period of years. The reason, of course, is that doctors seek the financial and professional advantages of city practice. Now that the war has further aggravated the plight of the rural and low-income sections of the country, States with the fewest physicians in relation to population have contributed the largest proportions of their medical manpower to the armed services. In addition, there has been a large-scale migration of people to wartime boom areas where there were not enough physicians to take care of even the pre-war population.

Although the Procurement and Assignment Service of the War Manpower Commission has succeeded in persuading some physicians to move into these sorely pressed communities, it cannot hope to effect all the necessary relocations through persuasion alone. Therefore, it has been proposed that funds be provided to enable the Public Health Service when necessary to pay transportation expenses and limited subsidies to physicians who will agree to practice in the communities where they are most

needed. It is proposed that when physicians cannot be obtained by this method the Public Health Service shall assign medical personnel to render essential services.

This, of course, is an emergency plan. If it is adopted it will serve only to alleviate certain unusually critical situations brought about by the war. After the war we shall be faced with the necessity of finding some means of stopping the progressive loss of physicians in rural and low-income areas, and of supplying physicians for regions that have never had an adequate standard of medical service. There is no reason to expect that unfettered operation of the law of supply and demand will work any better in the future than it has in the past. Besides, demand is not always a reliable gauge of the need for medical care. People who do not know what good medical care is have to be taught, and the only way to teach them is to give them a sample of what you have to offer. It is sometimes said that certain communities are accustomed to getting along without doctors and would not know what to do with doctors if they had them. All this means is that the people there are used to the idea of being sick and dying without having a doctor attend them.

Medical Personnel Limited

With medical personnel so limited, it becomes doubly important to train auxiliary workers who can assist the doctor in a capable manner and save his time and energy by giving the mother proper instruction. A large part of the deficiency now prevailing in maternity care in many parts of the country could be met by extension of health-department services, especially in the field of public-health nursing. At the present time only about 1,800 of the 3,072 counties in the United States are served by full-time, professionally staffed health departments. Many of these departments, moreover, are little more than skeleton organizations, and their public-health-nursing resources seldom exceed 1 nurse for each 10,000 population. If an adequate standard of community nursing service is to be maintained, this ratio should be brought up to 1 nurse for each 2,500 people.

In the past we have been unwilling to explore the possibility of utilizing in an organized way obstetric attendants below the grade of physician. The so-called midwives who attend a high proportion of births in the southern part of the country are in reality nothing more than uninstructed neighborhood women who help one another out to the best of their poor abilities for a few days near and during the time of confinement. It is highly doubtful if the practice of these persons can be improved in any substantial degree. On the other hand, the nurse-midwife type of attendant now being trained by the Maternity Center Association represents a great advance over the unskilled service which is all that is now available to many mothers. My organization, the United States Public Health Service, appreciates the oportunity it now has to share in the financial support of this movement.

The need for additional hospital facilities is also apparent. And, like physicians, hospital beds should be distributed according to need rather than community wealth and resources.

If all maternity cases in 1941 had been given the 10 days of hospital care recommended for uncomplicated deliveries, a total of approximately 82,500 maternity beds would have been needed.[2] If we assume, on the basis of the accepted formula, that there were five-sixths as many maternity beds available as there were bassinets, the number of beds available in 1941 was 59,500, or less than three-fourths of the number required. Moreover, some of the beds theoretically assigned to maternity care were used for other purposes.

Generally speaking, hospital facilities are most inadequate in the areas where physician shortages are most pronounced. In 1941 the States that were more than 70 percent urban had 434 hospital beds per 100,000 population, whereas the States that were less than 30 percent urban had only 214. States with a per capita income of more than $600 had 410 beds per 100,000; those with a per capita income of less than $300 had only 172.[3]

Shortage of Maternity Beds

To illustrate how extreme this deficiency is in some places let us consider the State of Arkansas. If all the maternity cases in that State in 1941 had received the recommended 10 days of hospital care, approximately 1,300 maternity beds would have been needed. Yet only about 350 were available. There are States where the discrepancy between the number of maternity beds needed and the number available is even greater.

Here, then, will be an appropriate field for action in a post-war public-works program. Some additional hospital facilities are being provided now under the terms of the Lanham

[2] Adjustment made for multiple births. Computed on the basis of 25,631,550 bed-days with 85 percent full-time occupancy.

[3] These figures exclude such special hospitals as tuberculosis and mental-disease hospitals and veterans' hospitals.

Act, but shortages of building materials have made it impossible to construct anything but the most desperately needed facilities in relatively few war areas.

After hospitals are constructed they will have to be maintained and operated. Since individual and community resources in many places are not sufficient for this purpose, public assistance will be needed. Local health departments and voluntary hospital associations are the agencies best equipped to assume responsibility for operation, although financial grants from State and Federal sources undoubtedly will be required to insure full utilization of the facilities.

Another requirement for better maternity services is the provision of adequate health centers. Most local health departments today carry on their activities amidst surroundings that might charitably be called unfortunate but that frankness compels one to describe as disgraceful. They are relegated to the basements of city halls or county courthouses and shunted into dilapidated, out-of-the-way structures which other agencies would scorn to accept. Not only is it physically impossible to render good service in such quarters, but there is little chance to develop the kind of relationship that should prevail between department personnel and the recipients of care. This relationship is especially important in handling maternity cases.

The financial burdens of pregnancy and childbearing fall into two categories: (1) The cost of medical care, together with the loss of income sustained if the woman is gainfully employed, and (2) the added responsibilities and expenses that parents assume when a child is born.

Maternity Care Expensive

Because of the high cost of adequate medical and hospital care, there does not seem to be even a remote hope that many people in the low-income groups can arrange to pay for such care out of their own resources. For example, in 1939, 18 percent of the individuals who worked on farms had cash incomes of less than $100, and 40 percent had less than $200. In 1941, 15 percent of rural farm families had net money incomes of less than $250, and 33 percent had less than $500. If these people somehow or other should arrange to pay in the neighborhood of $100—a conservative estimate of what a fairly reasonable kind of care would cost in rural areas—the resulting deprivation of food and other necessities of life would probably more than offset the health benefits of such care. Therefore, some form of financial aid would seem to be the only solution.

For some parents, however, the cost of medical and hospital care is only the beginning of the financial strain imposed by having children. The mother who must return to work after her child is born is faced with the problem of seeing that the infant is properly cared for. Consequently, the interest of society in easing the financial burden should extend to the provision of child-care services, at least during the period of early infancy.

There is a broader justification for expansion of maternity programs than the benefits such expansion would confer on individual mothers.

In the early days of human history propagation of the race was left largely to blind operation of the sex urge. This was sufficient for the end in view, because offspring entailed few obligations on the parents. During the pastoral and agricultural stages of man's development, children became actual assets. The more hands a family had, the more it got out of the soil and the more it prospered. The industrial revolution did not immediately alter this situation, for until industry was brought under a degree of social control most children were put to work at an early age.

Children a Financial Liability

Later, increasing social consciousness and the practical necessity for developing skilled workers brought about restrictions on child labor. Compulsory school attendance was instituted, and the period of schooling was gradually extended. As a result a child is no longer a financial asset; instead he is, financially, a decided liability.

Yet society has taken almost no account of this change. It has made little effort to compensate those who are willing to assume the increasingly heavy responsibilities of parenthood. Therefore, it is not surprising that people today are not so ready to propagate as they once were. Despite the present abnormal wartime increase in the birth rate, I believe we can assume that the downward trend will reassert itself after the return of more normal times.

History teaches us that a vigorous nation usually has an increasing birth rate. A steadily declining birth rate, on the other hand, is apt to be a sign that a nation's best days are over. Sooner or later we in America will come to grips with this problem. The question of incentives and added safeguards for maternity will then be raised as one of broad national policy.

Inter-American and National Services for the Children of the Americas

By KATHARINE F. LENROOT, *Chief, Children's Bureau, U. S. Department of Labor*

For the first time since 1924, the writer this summer had the opportunity of making the circuit of South America, down the west coast, across the Andes, and up through Brazil, the Guianas and Port of Spain, to Miami. Nineteen years ago, by boat, the trip took 20 days from New York to Santiago, 18 days from Buenos Aires to New York. This time, by air, the entire period covered only 1 month—8 days in traveling by plane and the remainder in stops ranging from a few hours to 8 days in six of the American Republics. But it was not the miracle of aviation nor even the growth of the great, modern cities of both the west and the east coasts, but the greater miracles of social progress, that made the trip a revelation and an inspiration—the development of the professions engaged in social service, public health, nutrition, and related undertakings; the scope and orientation of the far-reaching public and private services for children; the emphasis upon the importance of making security and opportunity for children central in national policy; and the official and informal cooperation and interchange among Nations to achieve these ends.

Underpinning and pervading all were the lasting friendships, the strength of common devotion and common purpose, enduring through two decades and full of promise for the future. It has been said that an institution is "the lengthened shadow of one man," and indeed the American International Institute for the Protection of Childhood is the lengthened shadow of its founder, beloved friend of the children of Uruguay and of the world, Dr. Luis Morquio, to whose beautiful statue in a Montevideo park children and adults delight to bring their offerings of flowers. Even more, cooperation between countries is enduring and fruitful only as the bonds of understanding, friendship, and mutual interest exist among individual citizens. Thus it was the kindness, thoughtfulness, and friendship extended in every country, from the time one stepped from the door of the plane, or the night boat to Montevideo, to the time one waved good-bye to companions who at dawn had escorted their guest to the airport, that lend warmth to all one thinks, says, and writes of an unforgettable experience. The arrival in Buenos Aires on the morning of the Revolution of June fourth but intensified the feeling of shared experience and common devotion to democracy and a secure place for children in societies in which freedom has been and must be native and cherished.

The main purpose of the trip, made under the auspices of the Department of State and with the cooperation of the Office of the Coordinator of Inter-American Affairs, was to attend a meeting of the International Council of the American International Institute for the Protection of Childhood. Other objectives were to confer with the chairman and members of the provisional inter-American committee of schools of social work, created in the United States at a meeting of directors of schools in June 1941; to visit national and other child-welfare institutions and agencies; and to confer with officials and individuals concerning the most fruitful methods of inter-American cooperation in matters pertaining to the health, education, and welfare of children. The writer left Miami May 18 and returned June 21. In that period she had opportunity for brief visits or longer contacts in Panama, Peru, Chile, Argentina, Uruguay, and Brazil. Plans to visit Bolivia and Paraguay proved to be impossible to carry out.

Meeting of the International Council

The Council met at the headquarters of the Institute, in Montevideo, May 28 to May 30, inclusive, with members or officials from 10 countries in attendance, including technical delegates or members from the United States, Peru, Chile, Cuba, Argentina, and Uruguay; and diplomatic representatives from Bolivia, Costa Rica, Mexico, Peru, Venezuela, and the United States. The President, Dr. Gregorio Aráoz Alfaro of Argentina, the Director, Dr. Roberto Berro, and the Secretary, Dr. Víctor Escardó y Anaya, conducted the work of the Council and arrangements for delegates with the utmost thoughtfulness and efficiency. The meeting had been called especially to consider (1) the study of nutrition which had been made on the basis of reports submitted by Governments, and (2) proposals for extending and

Meeting of Council of American International Institute for the Protection of Childhood, Montevideo, Uruguay

strengthening the work of the Institute in the spirit of the recommendations of the Eighth Pan American Child Congress, which met in Washington in May 1942. Cooperation in the nutrition study had been given through Marjorie M. Heseltine, nutritionist on the staff of the United States Children's Bureau, who prepared a report submitted to the Council by the United States delegation. The Director of the Institute presented a report on nutrition, accompanied by a chart showing food consumption and other data for 13 American countries; oral reports for 2 other countries were submitted.[1]

Proposals for expanding the work of the Institute and a plan of work for the next biennium, made by the technical delegate from Peru, Dr. Manuel Salcedo, the technical delegate from Chile, Dr. Guillermo Morales Beltramí, and other delegates, were given careful study by special committees and by the officers of the Institute and formed the basis for the recommendations which were adopted. Briefly, these provide as follows:

1. For the creation of national advisory committees to assist the technical delegates in their work.
2. For meetings of the Pan American Child Congress every 4 years and meetings of the International Council of the Institute every 2 years.
3. For a technical advisory committee to the Institute, to review and approve the program of work.
4. For the organization of three technical sections, dealing with child health, including nutrition, education, and social welfare, each in charge of a full-time director.
5. For the organization of regional work in four regions, each region to be the responsibility of a technical delegate, responsible for direct personal contact with the countries in the region. The headquarters for the regional work will change every 2 years, in order that each country in turn may have such responsibility.

The resolutions provide for a continuing Technical Advisory Committee composed of three technical delegates who, together with the President of the Council and the Director of the Institute, would study and approve the programs of work presented by the chiefs of sections and the suggestions transmitted by the delegates in charge of zones. The delegates of Chile, Peru, and Venezuela were named members of this committee.

The zones into which the continent is divided for regional work and the technical delegates made responsible for these zones for the next 2 years are as follows:

North America and the Caribbean, in charge of the technical delegate from the United States.

Northern South America (Panama, Colombia, Venezuela, and Ecuador), in charge of the technical delegate from Venezuela.

Pacific (Chile, Peru, and Bolivia), in charge of the technical delegate from Chile.

Atlantic (Argentina, Paraguay, Uruguay, and Brazil), served directly from the headquarters of the Institute.

The Director of the Institute will be especially charged with maintaining close contact between the regions and sections, in order to conserve the unified and harmonious character of the work.

[1] Better Nutrition for the Children of the Americas. *The Child*, vol. 8, pp. 31–32 (August 1943).

The President of the Council and the Director of the Institute were entrusted with the responsibility for preparing the regulations and budgets for the new organization. These will be submitted to the technical delegates of member countries, who should make comments within a period of 60 days following submission, in order that the plan and comments may be submitted for the consideration and action of the Council. If no reply is received within 60 days, the plan will be deemed to be accepted without comment.

Inter-American Cooperation in Professional Education for Social and Health Services

The recommendations adopted by directors of schools of social work in June 1941 related in part to the work of a provisional inter-American committee of which Dona Stella de Faro of Brazil was named chairman, Señora Luz Tocornal de Romero of Chile, vice chairman, and Señorita Estela Meguira of Argentina, secretary. Conferences were held with these and other members of the committee and with Dr. Alberto Zwanck, Director of the School of Social Work of the Museo Social Argentino, which bestowed upon the writer the diploma of corresponding member in exercises at which both Dr. Zwanck and Señorita Marta Ezcurra, Director of the Catholic School of Social Work in Buenos Aires, spoke. The cooperation between these two schools in Buenos Aires is one of the most significant aspects of the development of professional training in that country.

It was agreed that the chairman of the committee would send a questionnaire to all the schools of social work asking for specific information in accordance with items suggested by Señora de Romero and Señorita Rebeca Izquierdo of Chile and others. This questionnaire will cover the organization of the schools, admission requirements, courses of study, field work, availability of fellowships for foreign students, relationships with allied fields such as public-health nursing, and other subjects.

Plans are being made for a conference of directors of schools, to be held next year, probably in Buenos Aires on the call of Dr. Zwanck, the director of the second oldest school on the continent. At this conference the development of basic requirements for schools of social work will be one of the principal subjects on the agenda. Development of such standards is very important as new schools are being established rapidly, in provincial as well as capital cities.

The oldest school of social work in South America, established in 1925, is the school under the direction of the welfare board (Junta de Beneficencia) of the city of Santiago de Chile, of which Señora Luz Tocornal de Romero is director. This school offers fellowships to students from other countries. A Bolivian student is the present holder of the fellowship. The National Institute of Nutrition of Argentina, whose program includes scientific studies and practical service, offers two fellowships each year to each American Republic. Former students of the Institute are carrying on important nutrition work in Bolivia and other countries, as well as in two of the provinces of Argentina—Santa Fe and Mendoza. The Institute trains physicians, dietitians, and social workers in the principles of nutrition and their practical application, the training for social work being carried on in cooperation with the school of social work of the Museo Social Argentino. Great emphasis is placed on the family as the unit for nutrition service.

There is need for the establishment in the metropolitan centers of South America of associations of social workers which will not be confined to the graduates of a single school, and for greater cooperation among the schools. Clarification of the role of the social worker, the health visitor, and the nurse is needed in some countries. There is great interest in opportunities for study of social work, child guidance, maternal and child health, and other subjects. It is important that such opportunities be available both in the United States and in other American Republics, and that practical experience in other countries as well as in the United States, particularly in rural work and in the development of Nation-wide programs, be made available for all. Substantial modifications and adaptations of such experience to the needs of particular regions and indigenous cultures will be necessary in certain parts of the continent.

Progress in National Services for the Health and Welfare of Children

The development of social-security laws in Chile, Peru, Brazil, and other countries affords extensive resources for maternal and child-health work. Chile's law was passed in 1924 and is much more extensive as to coverage and benefits provided than the social-security legislation of the United States, since it covers agricultural and domestic workers and provides insurance against the contingencies of illness, maternity, permanent invalidism, industrial accidents, and old age. Cash payments and extensive medical benefits are also provided, and physical examinations are required at

regular intervals. In Lima a modern and well-equipped workman's hospital has been established as part of the social-security program, with maternity, infant, and child-health services as well as services for adults, a school for nurses, and a social-service department which affords field experience to all students of the Lima School of Social Work. Eleven regional hospitals have been provided for also as part of the social-security program. In Brazil medical, legal, old-age, and nutrition assistance is given to insured workers, grouped by occupations. Complete family meals are sent by the nutrition service of the Social Security Branch of the Department of Labor, Industry, and Commerce to families of the unemployed for periods of 20 to 30 days. The National Institute of Nutrition of Argentina also sends food rations to needy families in certain districts.

Low-cost restaurants for workingmen, dining rooms for expectant mothers, children's dining rooms, and school-lunch programs have been extensively developed in South America under both public and private auspices, and housing projects are also in operation. There is little in the way of cash assistance to needy families aside from cash benefits under social-security laws. It is recognized that much must be done in family education as to nutrition and standards of living. Studies of family living standards are made by nutrition institutes and schools of social service. Schools training health visitors are in existence in Buenos Aires, Montevideo, and elsewhere, and a number of schools of nursing have been established. The Uruguayan Child Council is developing a 9-month course for rural educators in maternity and childhood.

National children's departments have developed extensive health and social services for mothers and children and are extending their services as rapidly as possible outside the capital cities. The development of these departments has been greatly influenced by the work of the United States Children's Bureau and the Pan American Child Congresses. The Center for Maternal Education of the National Institute of the Child of Peru gives courses in family education, public health, and child care to young people of both sexes, engaged girls, and mothers of families. Child-health conferences and home incubator service for premature infants are also carried on in this center. The director of the Institute is most anxious to develop Nation-wide maternal and child-health services.

In Chile the "Dirección General de Protección a la Infancia y Adolescencia" was established in the Ministry of Health, Security, and Social Assistance. The preamble to the decree cites the resolutions of the Eighth Pan American Child Congress and the importance of preferential attention by the Government to the protection of maternity and childhood. Among the functions of the new office are the guidance and coordination of the work of semipublic, municipal, and private organizations and formulation of general standards for their operation. Preventive and curative maternal and child-health work, child-guidance clinics, children's homes, settlements, children's clubs, foster-home and other services for children in need of special care are among the services provided. A recent report on services to children in Chile by the director stresses the advantages of foster home over institutional care and states that children in foster homes will be supervised by pediatricians, social workers, and visiting nurses. A private children's organization (Consejo de Defense del Niño) in Santiago maintains day-care centers for children of working mothers and other activities.

Argentina is developing maternal and child-health centers in many parts of the country under the national "Dirección de Maternidad e Infancia." The social-security and child-welfare legislation of the Province of Santa Fe is particularly advanced, and courses for social workers have been established in Rosario. The national child-welfare agency (Patronato Nacional de Menores) maintains a number of institutions, of which an agricultural and industrial colony for boys on the cottage plan and a similar, though much smaller, school for girls are particularly notable.

The public child-welfare work of Uruguay is centered in one agency, the Uruguayan Child Council, which has abandoned entirely the concept of orphan asylums, substituting therefor an extensive child-placing system, homes for study and short-time care, and cottage-plan institutions for young people committed through court action. Extensive maternal and child-health services are also carried on by this organization. A Nation-wide private child-welfare organization has developed school lunches, nursery schools, and children's centers on a neighborhood basis, and a society for crippled children maintains a school under the devoted and competent direction of a young woman who has studied in the United States.

The National Department of the Child of Brazil, established in its present form after careful study of the United States Children's Bureau, has established maternal and child-health centers in many parts of Brazil, does extensive educational work, and conducts a

demonstration hospital for children in Rio de Janeiro, where clinical research is carried on.

These developments have been stimulated by national child-welfare conferences, the most recent being the one held in Peru in July of this year under the auspices of the Pediatric Society of Peru. In general, pediatricians have been pioneers in the development of services for children, including, in some countries, social services. Señora de Benavides, wife of the former President of Peru, Señora de Prado, wife of the present President, and Dona Darcy Vargas, wife of the President of Brazil, have given great impetus to the development of services for children and social services in these countries. The Welfare Society of Buenos Aires, founded in 1823, is managed entirely by women, as are similar welfare boards in a number of other cities, and maintains hospitals and institutions which receive large Government subsidies. In Rio de Janeiro and São Paulo the women have been organized for civilian-defense work under the leadership of Dona Vargas, and are developing extensive child-welfare services, including a cottage-plan institution for girls.

In a brief trip, and briefer report, only the most conspicuous examples of trends and developments can be observed and recounted. Although much has been accomplished, the outstanding impression of a visitor to South America is the conviction of those one meets that we are only on the threshold of a movement which must receive much more complete recognition if the children of the New World are to be given the opportunities that are essential to enable them to play their part in developing a civilization of and for free men working together for the common welfare.

First National Child-Welfare Congress in Peru

The First National Child-Welfare Congress of Peru met in Lima, July 3–10, 1943. It was attended by representatives of child-welfare and social-welfare agencies, scientific organizations, and municipal governments. At the invitation of the Congress, the Children's Bureau of the United States Department of Labor sent a delegate—Marjorie M. Heseltine.

Immediately before the opening of the Congress, a "Mother and Child's Week" (La Semana Materno-Infantil) was celebrated throughout the country. Groups of professional workers and of citizens held meetings to discuss maternal and child-welfare problems of the province or municipality. Visits were scheduled to hospitals, health centers, and other agencies to acquaint the public with the work in behalf of mothers and children. Daily radio broadcasts by leaders in child health, child welfare, and education supplemented the conferences and visits of observation.

The Congress, organized by the Pediatric Society of Peru, was held under the auspices of the Government. The President of the Republic delivered the inaugural address and presided at the opening session.

The announced purpose of the Congress was to consider the child from the biologic and social point of view. The Congress worked in four sections: Medical and surgical pediatric problems; public health; health and welfare work for children; mental hygiene of children and child-welfare legislation.

The speakers emphasized the importance of child protection through awakening in parents a sense of responsibility toward their children and through providing on a national scale proper housing and food for children, health education for the public, and trained staffs for welfare agencies.

As signs of progress in Peru, the delegates reported the recent organization in cities of child-welfare committees consisting of physicians, judges, teachers, and parents; the drafting of a children's code, the early enactment of which is expected; the enlargement of hospital and dispensary facilities for children in several cities; the establishment of prenatal clinics and child-health centers; and the employment of nurses to visit mothers and infants in their homes. As a signal achievement mention was made of a presidential decree, issued the day before the opening of the Congress, establishing a National Maternal and Child-Welfare Service (Servicio Nacional de Protección Materno-Infantil). This service, under the National Bureau of Public Health, is to have charge of both health and welfare work for mothers and children throughout the country and to coordinate and supervise the work done by public and private agencies. The service is to be directed by the head of the National Institute of the Child (Instituto Nacional del Niño), official agency in charge of maternal and child-health work.

The Congress, inspired by the principle of continental solidarity in the matter of child protection, announced itself in favor of a "charter of rights for the Peruvian family." The component elements of this charter were

embodied in the resolutions of the Congress, which emphasized that security for the child is the responsibility of society and called for placing the family on a sound moral, legal, and social basis. This would require: For the head of the family, whether man or woman, sufficiently well-paid work; for the family group, wholesome living quarters, educational opportunities, economic advancement with the growth of the family, and public aid in case of illness or other emergency; for the mother, suitable medical care and social service during pregnancy and at childbirth, instruction in child care, and income sufficient for the proper care of the child; for the child, conditions permitting normal growth and development—family life, proper food, attention to his physical and moral health, educational opportunities, and vocational guidance.

As measures toward the practical application of this program the Congress recommended: (1) enactment of laws relating to family welfare; (2) provision for all mothers and children of medical care, social service, and education; and (3) coordination of the technical, financial, and administrative work of the country's agencies serving mothers and children.

• EVENTS OF CURRENT INTEREST •

Death of Dr. A. T. McCormack

The Children's Bureau has lost a valued adviser through the death on August 7, 1943, in Louisville, of Arthur Thomas McCormack, M. D., Dr. P. H., State Health Commissioner of Kentucky.

Dr. McCormack, who was born August 21, 1872, had been Kentucky's State health commissioner for more than 30 years. He and his father, Dr. J. N. McCormack, whom he succeeded, have been the only State health commissioners Kentucky has ever had.

Friendly, diplomatic, courageous, Dr. McCormack was known internationally as well as nationally for his work in the development of public-health services, which he continued almost to the day of his death.

Resolutions of the National Education Association

At its representative assembly in Indianapolis, June 29, 1943, the National Education Association of the United States adopted resolutions relating to educational affairs in wartime and the post-war period. In regard to juvenile delinquency it urged that the schools, in cooperation with other agencies, develop a constructive program to counteract those forces which are contributing to juvenile delinquency, and strongly recommended the adequate enforcement of all laws designed to protect the interests of youth; the guidance necessary to enable youth to serve their country in the capacities for which they are best qualified; and such administrative changes or measures as may be necessary to emphasize and promote more specifically character education in the schools of our Nation.

CONFERENCE CALENDAR

Oct. 5–7 ____ National Safety Council. Thirty-second national safety congress and exposition. Chicago.

Oct. 8–10 ___ International Association of Governmental Labor Officials. Twenty-eighth annual conference. Chicago.

Oct. 12–14 __ American Public Health Association. Wartime conference and seventy-second annual business meeting. Permanent headquarters: 1790 Broadway, New York City 19.

Nov. 7–13___ American Education Week.

"Back to School" Campaign

The Children's Bureau and the Office of Education are initiating a back-to-school campaign to reduce child labor and encourage attendance at school during the new school year.

To this end a pamphlet, Back to School, containing suggestions for a fall campaign, has been prepared jointly and issued by the Children's Bureau (Washington, 1943. 12 pp. Processed).

This leaflet sets forth ideas for convincing children and grown-ups of the need of youth for education and the need of the country for educated youth.

"We must find the words that ring positive notes in the ears of our youngsters," says the leaflet, "that make them feel that they are important in a world at war and that their very youth is the most precious asset that the Nation owns. We must find the words to convince adults that the unplanned child labor we are permitting now is the most expensive way possible of meeting labor needs."

If boys and girls in essential jobs cannot be replaced from suitable labor reserves, the leaflet urges that properly guided projects be worked out for part-time jobs and part-time school.

New and Revised Children's Bureau Publications

Maternal and Infant Care

Standards and Recommendations for Hospital Care of Newborn Infants, Full-Term and Premature. Publication 292. Washington, 1943. 14 pp.

Assistance to hospitals in maintaining the high standards that have been developed in recent years for the care of newborn infants, while modifying some procedures to meet wartime conditions, is offered by this pamphlet. A statement of standards representing in general the consensus of present pediatric opinion is given, not as minimum standards pointing out the least that can be done for infants in hospital nurseries without jeopardizing their lives, but rather as standards pointing out the type of care for such infants that will best safeguard their health.

Baby's Daily Time Cards. Revised 1943. Five cards, giving daily routine and training for babies from birth to 1 year of age.

The Expectant Mother. Folder 1. Revised 1943.

Breast Feeding. Folder 8. Revised 1943.

Out of Babyhood Into Childhood. Folder 10. Revised 1943.

Emergency Maternity and Infant Care for Wives and Infants of Enlisted Men in the Armed Forces. Folder 29. 1943.

Child Care

Supervised Homemaker Service; a method of child care. Publication 296. Washington, 1943. 36 pp.

Basic procedures and fundamental principles in the organization of a program of homemaker service are outlined in this bulletin for the use, primarily, of workers in family and child-placing agencies. The bulletin should be of value also in determining how homemaker service may be adapted for use in a community program for the care of children of employed mothers. The material is based on discussions initiated by the Committee on Supervised Homemaker Service, which is composed primarily of representatives of private social agencies that have used homemaker service as one method of giving assistance to families. Case illustrations of five types of homemaker service are included in the appendix.

The Selection and Training of Volunteers in Child Care. Children's Bureau Publication 299. Washington, 1943.

Prepared by the Children's Bureau in cooperation with the Office of Civilian Defense, this manual brings together for the use of child-care committees and community agencies that handle the training of child-care aides, suggestions gathered from various sources as to the training of volunteers.

The manual discusses the purposes of volunteer training, where the responsibility lies for organizing the courses, the selection of suitable volunteers, the planning and supervision of the course, techniques of teaching volunteers, and the placement of trainees.

The content is outlined for 12 lecture periods followed by discussions, and suggestions are given for field and observation trips and for additional practice and reading. The value of in-service training is emphasized.

Child Employment

Ten Questions Answered About the Child-Labor Provisions of the Fair Labor Standards Act of 1938. Folder 26. Revised 1943.

Hazardous Occupations Subject to a Minimum Age of 18 Years Under the Fair Labor Standards Act of 1938. Folder 27. Revised 1943.

Age Certificates Are the Employer's Protection Under the Fair Labor Standards Act of 1938. Folder 28. Revised 1943.

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